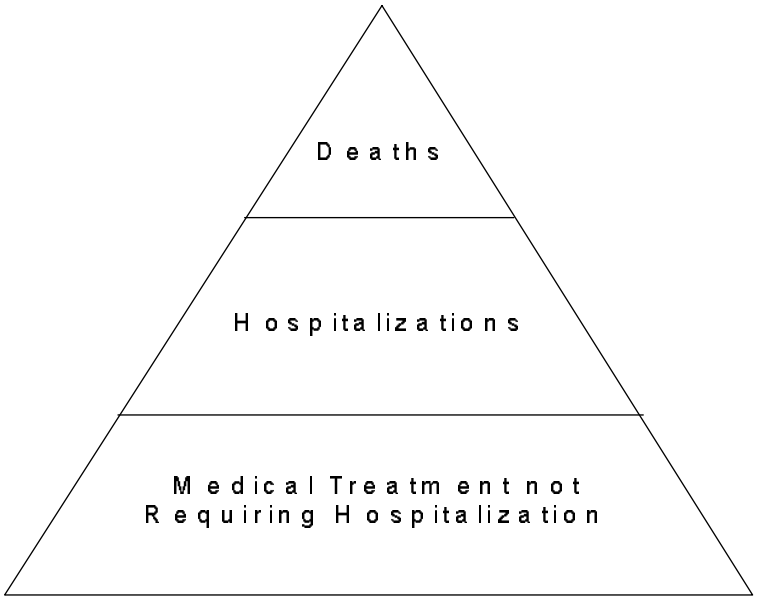
## INTRODUCTION

Injuries vary in severity. Unlike many diseases, the consequences of an injury, a burn wound for example, may range from trivial to devastating. The model below describes this range of severity:




The deaths that are included in the peak of the pyramid are the less common, but most severe outcomes of injury. Below that peak, there is a larger group of injuries with a severity level characterized by the need for hospital treatment on an inpatient basis. The largest group, found at the base of the pyramid, is characterized by the generally less severe, but most common injuries. These injuries generally receive medical treatment from a variety of sources including hospital emergency departments, private physician offices, walk-in clinics, school nurses, and athletic trainers. This last group is understood to be the largest, although there is no organized data system to describe its size or composition.

The data in this report mainly describes the middle level of the pyramid, patients with injuries that result in admission to hospitals. Several tables and charts of injury mortality are included to provide insight and perspective within the context of morbidity. This morbidity report should be used in conjunction with prior reports on injury mortality. They include a report titled "Injury Mortality in New York State" which presents data related to the leading causes of injury death in New York State, and a county-specific supplement, which provides several pages of data on injury risk groups for each county. Both the state level report and the county-specific supplement are available upon request from the New York State Department of Health, Bureau of Injury Prevention.

The injury morbidity data included in this report are derived from hospital patient discharge data as reported to the Statewide Program and Research Cooperative System (SPARCS). SPARCS refers to both a bureau of the New York State Health Department, and the data system which acquires and compiles the patient discharge summaries. The system was established primarily for regulatory and cost containment purposes, but it also contains valuable epidemiologic information useful to injury control practitioners. In addition to demographic descriptions of patients, the records contain information about the clinical nature of patients' injuries (N-codes), as well as the external causes of these injuries (E-codes).

This report presents data in groupings which were selected for their etiologic similarity. For example, the category titled pedestrian injury includes all interactions between a pedestrian and a motor vehicle, regardless if that interaction occurred in a typical traffic environment such as a crosswalk, or in a non-traffic environment such as a parking lot. Throughout this report the numeric sequencing of the E-codes contained in the ninth revision of the International Classification of

Diseases (ICD-9) has been reassembled to form etiologically similar groupings for the purpose of facilitating the development of specific injury prevention activities. Appendix 3 lists the E-codes included in each of the major injury etiologies so that the reader may refer back to the ICD-9 for specific descriptions of the categories included in each grouping. In addition, appendix 1 lists the E-codes excluded from the etiology groups and included in the "other" category, and appendix 2 lists those E-codes that are generally excluded from normal surveillance reports. Further, at any point in the document where rates are presented, the population data was derived from the 1990 census population.

Injury morbidity surveillance in New York is intended to be a continuous flow of data to practitioners, not a single document. The data will be presented in sections describing the injuries in etiologic groupings, such as motor vehicle crashes, assaults, bicycles, etc. Because not all sections can be produced, printed, and disseminated simultaneously, the data will be prepared on hole-punched paper, and contained in a loose-leaf binder to facilitate frequent additions and occasional revisions. The data flow will also include special topics such as brain injuries, spinal injuries, and burns. A comprehensive surveillance report will be the eventual compilation of topic-specific sections, to be issued at intervals.

Surveillance data are collected, analyzed, and disseminated for the use of practitioners. The sole purpose of the data in this report is to provide helpful information to injury control practitioners for their use in priority setting, program planning, and evaluation activities. Any feedback from practitioners on the usefulness of these reports is welcome and encouraged and will serve to enhance the future quality of this document.